HEADQUARTERS
UNITED STATES EUROPEAN COMMAND
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HEALTH SERVICE SUPPORT

Medical Crisis Response

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1. **Summary**. This publication establishes policies for coordinating the response of the United States European Command (EUCOM) Health Service Support (HSS) system to crisis situations.

2. **Applicability**. USEUCOM Directive (ED) 67-5 is a publication that establishes policy, assigns responsibilities, and prescribes procedures to a USEUCOM medical crisis response for Headquarters, EUCOM, and component commands.

3. **Internal Control Systems**. This directive does not contain internal control provisions and is not subject to the requirements of the internal management control program. For HQ USEUCOM and subordinate joint activities, the applicable internal control directive is ED 50-8, Internal Management Control Program.

4. **Suggested Improvements**. The proponent for this publication is the Command Surgeon's office, HQ USEUCOM. Recommended changes should be forwarded to HQ USEUCOM, ATTN: ECMD, Unit #30400, Box 1000, APO AE, 09128.

5. **References**. See Appendix A.

6. **Explanation of Terms**.

a. For purposes of this directive, peacetime crises include natural disasters, terrorist attacks, refugee care/humanitarian assistance, or other acts of violence not addressed by CINCEUR Operations Plans (OPLANS) or OPLANS of supported unified commands.

b. For purposes of this directive, the term MASCAL situation is as defined in reference a: "A Mass Casualty situation is one in which an excessive disparity exists between the patient load and the HSS capabilities available for its conventional management."

c. Nonstandard units. This term when used in context of this ED will refer to those task organized, medical crisis response units lacking a standard service component requirements document (i.e., Army and Marine Tables of Organization and Equipment, Air Force Allowance Standards, Navy Manning Documents).

d. Pallets are defined as standard USAF 463L cargo pallets.

This Directive supersedes ED 67-5, dated 26 June 1997.

e. Marshaled is defined as the time when a unit should be at the Aerial Port of Embarkation (APOE) with all personnel and equipment required to accomplish the mission in a ready-to-load status. It is measured from the time a unit is alerted to the time that unit is ready to fly (assuming the availability of aircraft). This readiness standard is prescribed in para 7 of this ED.

f. MEDCRT refers to the medical teams organized and directed to respond to a crisis situation. Specifically there are four types of MEDCRT: SRT-Surgical Response Team; MHRT-Mental Health Response Team; FSMT-Forward Support MEDEVAC Team; and RAMT-Radiological Advisory Monitoring Team.

7. **Responsibilities**.

a. Commander in Chief, U.S. European Command (CINCEUR).

(1) Direct and coordinate a HSS response to crisis situations which will include associated logistics, force protection, command, control, and communications.

(2) Provide guidance for component commands on personnel readiness requirements for Medical Crisis Response Teams (MEDCRTs).

(3) Monitor EUCOM MEDCRTs readiness status.

(4) Maintain current HSS capability studies and other available forms of medical intelligence on all countries within the EUCOM Area of Responsibility (AOR).

(5) Coordinate MEDCRT blood support, through the EUCOM Joint Blood Program Office (JBPO).

(6) Monitor theater medical forces to mitigate any impact upon peacetime health care resulting from a crisis response.

(7) Direct and monitor theater mental health assets for immediate response to a crisis situation or any event that warrants mental health intervention.

(8) Maintain and publish the MEDCRT deployment rotation schedule for the Surgical and Mental Health Response Teams.

b. Commanding General, United States Army Europe (CG, USAREUR); Commander in Chief, United States Naval Forces, Europe (CINCUSNAVEUR); Commander, United States Air Forces in Europe (COMUSAFE).

(1) Plan, program, equip, train, and maintain mission capable MEDCRTs for rapid HSS response to a crisis situation as prescribed in this ED. These teams will provide the initial medical response to a crisis that is limited by time and magnitude. Ensure deploying teams receive detailed intelligence briefings to include environmental issues and threat to US personnel.

(2) Provide hospitalization for patients evacuated from the disaster location or area.

(3) Monitor and coordinate HSS readiness requirements of all MEDCRTs within service component command. Notify EUCOM of shortfalls or limiting factors affecting component MEDCRT mission capabilities.

(4) Arrange for transportation of MEDCRTs, and their associated equipment and supplies, to the debarkation site for deployment to the crisis location or area.

(5) Coordinate all classes of resupply for deployed MEDCRTs, as required.

(6) Support EUCOM in monitoring the location and status of patients within the EUCOM AOR.

(7) Coordinate training exercises which integrate, validate and refine MEDCRT capabilities and procedures (e.g., MEDFLAGs, MEDCEURs, etc.).

(8) Establish procedures to ensure the readiness of MEDCRTs and their compliance with all standards prescribed by this ED, as applicable.

(9) Coordinate for the issuance of Official Passports to all MEDCRT members. A current list of all MEDCRT member names, ranks, Official Passport numbers, and location of issuance should be maintained at the component headquarters to expedite visa requirements.

(10) Be prepared to provide varying levels of support with respect to utilities, berthing, messing, transportation, command, control, communications, laundry, and force protection, etc. (MEDCRTs are staffed and equipped to provide necessary HSS for a limited period of time. MEDCRTs, even when supported by materiel resupply, are not capable of independent function)

(11) Provide the following two MEDCRTs with a minimum capability of:

(a) Surgical Response Team (SRT)

1 Deploy all unit and personal equipment on one C-130 (limited to three 463L pallets and 25 personnel).

2 Life saving surgical intervention for 20 patients in a 48 hour period to include provision of requisite Class VIII.

3 Capable of providing individual shelter, fuel, food, and water for 48 hours.

4 Marshal the SRT at the designated embarkation point within 12 hours of notification.

5 Initial blood supply should be coordinated with the adjacent MTF and

consist solely of Type O packed red blood cells (PRBC). The MTF and SRT should coordinate with JBPO to backfill the MTF and to fill out the SRT's projected requirements in accordance with reference o. Once deployed and operational, all resupply requests must be coordinated through the JBPO. Because the SRT is responding to a crisis scenario, Level II transfusion practices will be observed. For specific blood guidance, refer to Appendix C. Deploying SRTs must ensure that an appropriate blood bank-type refrigerator (i.e., Thermopol) is part of the deployment equipment package.

(b) Mental Health Response Team (MHRT)

1 Provide sufficient mental health professionals and support staff to render immediate mental health intervention before, during, or after a military operation or crisis situation.

2 The MHRT will be lead by a mental health professional in the grade of 03 or greater.

3 Be prepared to marshal the MHRT at the designated embarkation site within 12 hours of notification.

(c) Service components will share SRT and MHRT crisis response alert duties on a rotating basis. The schedule will be published annually by HQ USEUCOM Surgeon's Office. Alert duty will be scheduled for one-month periods by component. If a component MEDCRT is alerted for deployment by USEUCOM, the next component on the schedule will assume the remainder of that months duty as well as its own scheduled month.

c. CG, USAREUR.

(1) Provide a Forward Support MEDEVAC Team (FSMT), ready for deployment within 24 hours of notification, for medical evacuation of patients and transport of medical personnel and supplies.

(2) Provide a Radiological Advisory Monitoring Team (RAMT) which is capable of deployment within 24 hours.

d. CINCUSNAVEUR.

(1) Be prepared to provide a medical crisis response with primary casualty receiving and treatment ships.

(2) With available assets, provide fixed-wing aircraft and aircraft crews to augment USAFE and AMC assets in the movement of MEDCRT personnel, material and patients, as required.

(3) If Amphibious Readiness Group (ARG) is available, augment crisis response forces with rotary-wing aircraft and crews for patient evacuation, transport of MEDCRT personnel, and the movement of materiel as required.

e. COMUSAFE.

(1) Coordinate AE operations in support of patients generated by the crisis.

(2) Provide aircraft and crews, and other appropriate aeromedical evacuation assets for patient evacuation, and for movement of MEDCRT personnel and supplies responding to the crisis.

(3) Regulate patients, through the Theater Patient Movement Requirements Center-Europe (TPMRC-E), to the most appropriate Medical Treatment Facilities (MTF).

f. Commander, Special Operations Command, Europe (CDR, SOCEUR). Provide unique capabilities in support of medical crisis response as required.

8. **Policy**.

a. Combatant Command (COCOM) of theater HSS resources is maintained by CINCEUR. In a crisis situation within the EUCOM AOR, Operational Control (OPCON), Tactical Control (TACON), Direct Liaison Authority (DIRLAUTH) of HSS resources may be delegated to a joint task force (JTF) commander. The EUCOM Surgeon will provide technical guidance and direction to the senior medical officer on the scene. EUCOM HSS resources deployed to locations outside EUCOM's AOR will be employed in accordance with established "supported" and "supporting" commanders relationships defined in JCS Pubs and operations orders which may evolve as a result of the crisis in accordance with reference f.

b. All HSS assets within EUCOM are available to support crisis situations within EUCOM's AOR as a part of a continuing medical response. Further, EUCOM HSS assets will support, upon request and within capability, crisis situations within other unified command AORs, in accordance with existing agreements or as directed by higher authorities.

c. HSS is a national responsibility. The HSS structure will be based on the principle of joint cooperation and effective coordination of all available HSS resources. Allied patients, host nation patients, and personnel from international Non-Governmental Organizations (NGO) in the crisis area will be provided care by U.S. forces personnel on an emergency basis in accordance with references c and e and Appendix B of this ED, unless other agreements are in place. Coordination for the repatriation of these patients will be initiated with the appropriate authority as soon as their medical condition permits.

d. Emergency hospitalization will be provided in the nearest available host nation, allied, or U.S. MTF with HSS capability commensurate with the patients' requirements. U.S. patients will be repatriated to U.S. facilities as soon as possible. Medical regulating of patients from the crisis location to a MTF for follow-on or definitive care will be coordinated between the senior

medical officer at the scene and the TPMRC-E. The preferred mode of evacuating patients is by air.

e. Blood and blood product support will be provided for EUCOM HSS crisis response efforts. Peacetime management and distribution of blood and blood products is coordinated by the EUCOM JBPO, through the component blood program offices (CBPO). Crisis or contingency requirements for blood or blood products resupply that are beyond the Service component commands' blood program capability will be coordinated through the EUCOM JBPO. Only blood procured through Food and Drug Administration (FDA) approved sources is to be used on U.S. personnel. Upon coordination with host nation medical sources, locally sourced blood products may be used on indigenous personnel. Ensure that US sourced blood products are stored separately from other sourced products.

f. Every effort will be made to redistribute medical resources, for bona fide medical requirements within the EUCOM AOR, through optimal intra-service and inter-service coordination. CONUS based HSS may be required to support a crisis or contingency situation if the magnitude of medical requirements exceeds the theater capability. All requests for CONUS based HSS will be coordinated with the USEUCOM Surgeon.

g. EUCOM component commands will maintain HSS assets prescribed by this directive in a high state of readiness for rapid deployment. These assets will deploy on order from HQ EUCOM.

(1) Personnel assigned to MEDCRTs will comply with component personnel pre-deployment requirements to include current vaccinations and other preventive medicine guidance and prophylaxis.

(2) The readiness status of MEDCRTs will be reported in "by exception" cases only. In those situations where the component will not be able to fulfill its scheduled MEDCRT rotation or one or more of the components MEDCRTs are not fully mission capable the report will contain the rationale and duration of the status. The "by exception" reports will be forwarded by the component surgeons' offices to the EUCOM Surgeon by the most expeditious means available.

9. **Procedures**.

a. When CINCEUR validates a requirement for a medical response to a crisis, EUCOM MEDCRTs will be placed on deployment alert or directed to deploy by the European Theater Command Center (ETCC) via the component commander.

b. HSS response to a MASCAL situation may be provided by one or more component MEDCRTs, or by specially configured MEDCRTs jointly staffed by component medical services.

c. Selected U.S. MTFs will be alerted, as necessary, to receive evacuated patients. Joint regulating of patients will be governed by the immediacy of the patient's needs and HSS availability in accordance with reference e.

10. **Command and Control**. CINCEUR will exercise COCOM and directive logistics authority in accordance with reference d.

a. If a JTF has been established, then command and control will be exercised through the JTF.

b. When a JTF does not exist and is not envisioned, then command and control will be exercised from USEUCOM through service component command channels.

FOR THE COMMANDER IN CHIEF:

OFFICIAL:

MICHAEL A. CANAVAN
Lieutenant General, USA
Chief of Staff

DAVID R. ELLIS
LTC, USA
Adjutant General

APPENDICES
A- References
B- Medical Rules of Engagement
C- Blood Guideline for SRTs

DISTRIBUTION:
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APPENDIX A

References

a. Joint Pub 0-2, Unified Action Armed Forces (UNAAF), 24 February 1995.

b. Joint Pub 1-03.3, Status of Resources and Training System (SORTS), 10 August 1993.

c. Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations, 26 April 1995.

d. Joint Pub 4-02.1, Joint Tactics Techniques and Procedures for Health Service Logistics Support in Joint Operations, 6 October 1997.

e. Joint Pub 4-02.2, Joint Tactics Techniques and Procedures, Health Service Support, 30 December 1996.

f. Joint Pub 5-03, Joint Operations Planning and Execution System, Volumes I and II, 4 August 1993.

g. Department of Defense Directive 6000.12, Health Service Operations and Readiness with Change 1, 20 January 1998.

h. Department of Defense Instruction 6000.11, Medical Regulating, 6 October 1998.

i. DA PAM 27-1, Treaties Governing Land Warfare, 7 December 1956.

j. DA PAM 40-19, Commander's Guide to Combat Health Support, 24 March 1995.

k. US Army Regulation 40-3, Medical, Dental and Veterinary Care, 15 February 1985.

l. US Army Regulation 40-13, Medical Support--Nuclear/Chemical Accidents and Incidents, 1 February 1985.

m. ED 67-1, Medical Service, XX February 2000.

n. ED 67-2, USEUCOM Patient Movement, 15 October 1998.

o. ED 67-4, USEUCOM Joint Blood Program, 22 August 1999.

p. STANAG 2879-3, Principles of Medical Policy in the Management of a Mass Casualty Situation, 7 September 1998.

APPENDIX B

Medical Rules of Engagement

The following pages of this appendix provide guidance to US EUCOM medical units for authorizing and providing medical treatment and aeromedical evacuation.

CATEGORY OF PATIENT	DOCUMENTS REQUIRED	EXTENT OF CARE			ADDITIONAL INFORMATION
		EMERGENCY	STANDARD EVACUATION	NON-EMERGENCY	
1 US Active Members; Active Duty (AD) & Active Guard Reserve (AGR)	Valid ID Card	Yes	Yes	Yes (Aid Station)	Assess to determine treatment in the MTF versus sending back to aid station; educate regarding sick call procedures in area of operations; evacuate to central region as warranted by medical condition.
2 US Reserve Service Members; Army National Guard & Reserve Component serving in a Title 10 status	Valid ID Card & TDY Orders	Yes	Yes	Yes (Aid Station)	Same as 1 above. Note: For routine care, treat only injuries/illnesses incurred/aggravated while on or enroute to training.
3 Retired (US) Service Members (regardless of present employer)	Valid ID Card	Yes	Space Available	Space Available	Non-emergent care may be subject to availability of services; transfer to Host Nation (HN) facility or evacuate to central region as warranted by medical condition.
4 Federal Civilian Employees (e.g., US citizens working for DOD in support of the current mission	Valid ID Card & Orders	Yes	Yes	Yes	Care authorized at no cost to employee; non-emergent care may be subject to availability of services.
5 NATO Forces Non-US, Non-NATO Forces in support of the current operation	Valid ID Card and/or Invitational Orders	Yes	No	No (Unless authorized with a Bilateral Agreement	Stabilize, then refer to their national medical system as soon as emergency period ends. Note: Evacuation to central region requires diplomatic clearance; evacuation to CONUS requires approval by the Service Secretary of the component providing the support.

6	Civilians in Emergency/Foreign or National Disaster:	The following categories of patients should only be provided emergent care, and must be transferred as soon as patients become stable. Patients who are ineligible, but present to the MTF seeking emergency care shall be evaluated and treated only if the physician determines that a patient care emergency exists. Reference Note 1 below for specifics regarding triaging prior to transporting civilian casualties to the echelon three facility. Treatment of civilians is required when injuries (regardless of severity) are caused by or are the direct result of US or allied forces' actions; transfer to appropriate civilian authority as soon as possible. On request of a life, limb, or eyesight saving movement, the senior medical officer or JTF-Surgeon may approve movement of ineligible US citizens when adequate care is locally unavailable, and suitable commercial evacuation support is neither available, feasible, nor adequate.				
6a	Local Nationals	ID Card (if available)	Yes	No	No	Emergency care is authorized; transfer to local hospital as soon as emergency period ends.
6b	Non-Government Organizations/ Private Volunteers					In the AOR pursuant to Invitational Orders in support of DOD.
	(1) Red Cross supporting US Forces	Picture ID	Yes	Yes	Yes	Non-emergent care will be subject to availability of services.
	(2) Peace Corps/ Beneficiaries of the Public Health Service	Picture ID & Authorization letter from Peace Corps Officer	Yes	Yes*	No*	* When coordinated with local representative. ** If space is available, non-emergent care may be provided; care must be authorized by letter.
	(3) Civilian religious leaders/ groups; celebrities/ entertainers; athletic consultants or instructors; representatives of social agencies/ educational institutes	Picture ID & Invitational Travel Order	Yes	No*	No	Emergency outpatient care authorized without charge; charges are incurred for inpatient care. * Routine evacuation support is not authorized; see exception at item #6 above.

	(4) USO Professionals	USO ID & USO Form 2FI-19029-F	Yes	No*	No	Stabilize, then refer to their health care system as soon as emergency period ends. * Routine evacuation support is not authorized; see exception at item #6 above.
	(5) Contractors	ID Card & US Passport	Yes	No*	No	Refer to contractor medic; charges are incurred for treatment; notify the MTF CDR for decisions on non-US passport holders. * Routine evacuation support is not authorized; see exception at item #6 above.
	(6) Press & Local National Interpreters	Picture ID & Invitational Travel Order	Yes	No*	No	Emergency outpatient care authorized without charge; charges are incurred for inpatient care. * Routine evacuation support is not authorized; see exception at item #6 above.
7	Department of State Designees	Valid ID Card	Yes	Authorized forward Medevac (ground/air) to appropriate medical facility	Yes	Based on the existing MOU, provide the level of medical care that is required same as that provided to US Armed Forces. Referrals/transports from area of operations to home nation is a national responsibility.
8	Detainees	Picture ID Card (if available)	Yes	No*	Yes	Provide the level of medical care that is required for US Armed Forces. Transfer to detainee collection point as soon as treatment period ends. * Routine evacuation support is not authorized; see exception at item #6 above.

Note: Guidance on Triage Prior to Transporting Civilian Casualties to the Medical Treatment Facility (MTF).
Triage of ill/injured civilians must occur prior to transport of civilian casualties to avoid evacuating noncritical casualties to the MTF.
Treatment options include:

a. Emergency care and evacuation to the MTF for life, limb, eyesight threatening injuries.
b. Emergency care to prevent deterioration and evacuation to civilian treatment facility for non-life threatening injuries.
c. First aid for minimal injuries.

APPENDIX C

BLOOD GUIDELINES FOR SRTs

1. **SUMMARY**. MEDCRTs possess extremely limited laboratory capabilities. Specifically, a MEDCRT does not possess any capability to perform blood bank testing, to include ABO grouping. Therefore, blood inventory is limited to only Type O packed red blood cell (PRBC) units. If the physician determines that a blood transfusion is needed to save the life of a patient and the patient can not be immediately evacuated to a higher echelon medical facility, then transfusions must be given based on the following procedures.

2. **Transfusion Procedures:**

a. Women of child bearing years have priority for Rh negative blood.

b. If there is not enough Rh negative blood to meet all of the needs, the use of Rh positive blood becomes an emergency requirement to save the life of the patient.

3. **Medical Implications**:

a. FEMALES: Transfusing Rh positive red blood cells to Rh negative females may result in future complications if the female is of child-bearing age. If this female develops an anti-D antibody and a future fetus is Rh positive, hemolytic disease of the newborn may result. The maternal anti-D antibody can cross the placenta and causes increased red blood cell destruction in the fetus resulting in increased serum bilirubin levels. As a result, the fetus may not compensate for the decreased oxygen-carrying capacity and severe anemia may develop, causing cardiac failure and edema, hydrops fetalis, and possible death in utero. The impact on hospitals in treating these types of conditions is enormous and costly. Once a maternal anti-D antibody is formed, Rh Immune globulin (RhIG), or Rhogam, is no longer effective. Thus, it is paramount to reduce the transfusion of Rh positive blood to Rh negative females of child-bearing age.

b. MALES: The impact of sensitization on males and the health care system is not quite as great as females. If a male develops an anti-D antibody, the only future problem area comes if the patient needs a blood transfusion in the future. At that point, the transfusing facility must ensure that only Rh negative blood is used. If not, a delayed transfusion reaction can be expected.

4. **Reporting and Record-keeping**:

a. The deployed MEDCRT must stay in contact with the JBPO either through telephone, e-mail or blood reports (BLDREP).

b. The deployed MEDCRT will utilize blood inventory tracking reports to maintain accountability and disposition of all blood products received. The two main reports are the Disposition Report and, in the event of blood transfusions, Transfusion Report. Reference *Joint Blood Program Handbook*, Army TM 8-227-12, Navy NAVMED P-6530, Air Force AFH 44-152 and *EUCOM Directive 67-4, dated 22 August 99.*

c. All blood records will be maintained, in an orderly system, to include all shipping documents, disposition reports and transfusion reports. Upon redeployment, all blood records

will be boxed and shipped via certified mail to HQ USEUCOM, ATTN: Office of the Command Surgeon (JBPO), Unit 30400 Box 1000, APO AE 09128.

5. **Storage Guidelines**:

a. Packed red blood cell units must be stored at 1 to 6 ^{o} C.

b. It is preferable to keep blood units in a blood bank-type refrigerator which has an alarm and a continuos temperature monitoring system (i.e. Thermopol NSN: 4110-01-287-7111). If the refrigerator does not have a continuous temperature monitoring system, then one of the team members must check and record the temperature every four (4) hours.

c. If a refrigerator is unavailable or malfunctions, then the blood units may be kept in the blood shipping box. The box must be repacked every 48 hours using 14 pounds of wet cubic ice. **NEVER USE BLUE ICE OR CHEMICAL ICE PACKS**. As ambient temperatures rise, re-icing will be required more frequently. A technician must check and record the temperature every four (4) hours.